

Asthma in Childhood



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So much has been written about asthma, and even asthma in childhood, that it is impossible to make an adequate review of it. I propose therefore instead to make a brief summary of those facts and opinions about asthma on which there is general agreement. As a first point all observers are agreed that there appears to be a certain kind of individual who develops asthma - and that this in very many cases, is associated with a family history of allergy.

Agreement exists secondly as to the physical conditions in the chest, which are the direct cause of the respiratory distress both in children and adults. This is due in infancy, to quote Dr. T.N. Fisher of Manchester, to 'turgid swelling of the mucous membrane of the smaller branches of the bronchial tree, with increased permeability and exudation of fluid'. Later, this situation comes 'gradually to be superseded by smooth muscle spasm with its characteristically more abrupt manifestation'.

The origin of this condition has been described as due to :- an imbalance between vague and sympathetic; an allergic condition; tissue damage; occult sepsis; unsatisfactory naso-pharyngeal conditions, particularly of the upper back part of the nose; adverse reactions to low altitudes and moist climates or to a combination of these factors.

On the personality side, it is argued by all observers that asthmatic subjects are suggestibles, that expectation plays a large part in the production of an attack; that asthmatic children are usually found to be embedded in a particular type of family situation, and that the whole personality of the child seems in some cases to be involved. It is also generally agreed that in many children who suffer from asthma, symptoms appear simultaneously of an accompanying neurosis. As regards the attack itself most observers are agreed that an attack can arise as readily from psychological stress as from physical stimuli, and that in children the attitude of the patient's surroundings play an important part in the total situation. Asthma has been the focus of study for physiologists and physicians, by pathologists, ear, nose and throat surgeons, psychiatrists, and paediatricians; and as many lines of treatment are being followed up as there are major workers in the field, and in each case with successful results. The main core of the problem is formed by the complexity of the pattern of stimuli, which give rise to the asthmatic attack.

It may well seem impossible to add anything useful to so much knowledge, but this paper is concerned with an attempt to present some facts concerning asthma in childhood and some conclusions, which arise from these facts, which do not follow any of the lines indicated above. These facts

and these conclusions have arisen in the course of an approach to the study of asthma extending over some fifteen years in which children are encouraged to demonstrate their view of their own experience and both what they do is studied and the children are treated along several lines simultaneously.

In what concerns the importance, in the general problem of asthma, of asthma in childhood according to analyses made by Dr. E.O. and G.G. Williams of Birmingham of statistics of 66 male and 36 female patients with asthma seen in adult life in 63.3% males and 75% females, the condition developed before the age of 11; and in the children with asthma studied by Dr. Fisher it first appeared in infancy in 48% and between 2 and 6 years in 39%.

If asthma be regarded from this paediatric point of view, it falls into five natural groups:

1. The early infantile type, so often mistaken for bronchitis.
2. The type in which asthma appears subsequently to early and severe eczema.
3. The type in which a child is subject to constant recurring catarrhal states, each of which tends to resolve into asthma with or without skin involvement.
4. The type in which a child develops recurrent attacks of asthma in association with a long series of different illnesses, usually including whooping cough
5. The type in which the asthmatic attack develops spontaneously and without association with either catarrhal or skin complaints.

I propose now to cite one illustrative case for each grouping and briefly summarise the history before and after treatment, so that you may know the type of clinical material I have in mind, — all the names used are fictitious and adopted for convenience.

Type 1

Alice Heath was a little girl of 10, the younger of two children of a lorry driver, in a rather distant county sent by the Authorities to the Institute of Child Psychology, because all other means of treatment had failed. Alice's mother was a mountainous, very limited woman, whose central desire in life was to make Alice 'a little lady'. There was no allergic history on either side of the family and the relations of the parents were good. The elder child, a boy, was a genetic oddity, of good intelligence and already at work. Alice's I.Q. was 78, but balanced by good manual dexterity.

Alice's history, up to the time she came to us, was typical of so many of those children — of full term and with spontaneous delivery, facial dermatitis

developed at 6 weeks. For the child's first year she was in and out of various hospitals, and splinted and tied down for nine months, so no reliable facts as to milestones could be obtained. Asthma appeared between 3 and 4 years, when the eczema improved. She had chicken pox, whooping cough and jaundice. At 9, skin tests were performed and she was found to be sensitive to hair, pollen, eggs, wheat and cereals. A series of injections were given. When first seen, she had never had animals, fur feathers or wool in contact with her, and slept on Kapok pillows. The only time she had been free of asthma in her life, was during a two weeks visit paid with her parents to Switzerland.

Physically, Alice was a typical asthmatic child with rounded shoulders rigid in an attempt to shield her breathing, low, hardly audible voice, with inhibited responses and unwilling to leave the shelter of her large mother.

The Natural History of Asthma — E.O. Williams MD, Ch.B. and G.E.O. Williams M.D. M.R.C.P B.M.J. Oct.22nd, 1940.

There was some anterior flattening of the chest, with a hyper resonant note and dry high pitched sibilant rhonchi, the nasal mucous membrane was pale and boggy, adenoids were present and the tonsils mildly enlarged, the skin showed some lichenised patches in the ante cubital spaces, and behind the knees and buttocks. Sociologically Alice's asthma dominated the household. It might come at any time in the night or the day. On average an attack lasting about two hours. At night Alice was capable of getting her parent out of bed three times in the night to look after her, make her hot drinks etc.

Alice was said to be terrified of dogs, and yet to seek them her mother had I fear of doctors, dentists, hospitals and the dark.

Alice attended the ICP twice weekly for nine months during which time the asthma ceased and the skin greatly improved. At the end of this time, arrangements were made by the Red Cross, owing to constant bombardment by the father, for her to go to school in Switzerland. While there, the doctor in charge wrote a report, which agreed in every particular with our view, namely, that Alice was now a Maladjusted child, needing discipline and good outlets, and not any longer an asthmatic child.

The latest report, two years and four months after we first saw her, is that Alice has not been absent once from school, and that apart from an occasional slight cough nothing unusual has been noticed about her by the new school to which aim has now gone.

Type 2

To pass from this type, to asthma in infancy. Here the question of diagnosis is All important, since in many infants, a condition which is really asthmatic, that is, not inflammatory, is diagnosed as an inflammatory condition, bronchitis or bronchi-pneumonia, and valuable time is lost in consequence.

Dr. TN. Fisher of Manchester, writing in 1946 of asthma in childhood describes the dilemma neatly as follows: "If muscle spasm plays an unusually predominant part, the onset of the attack is more abrupt and the child is more acutely ill, with obvious respiratory distress which, in these themolabile subjects, readily induces pyrexia. The picture then bears a superficial resemblance to broncho-pneumonia. A careful weighing of the family history, the type of onset and the general picture of the child in which, in asthma, the cardinal element of expiration, limitation and respiratory distress predominates, should make a correct diagnosis possible.

I would like to instance as an example of this type of child, Jane Eikins, a pretty fairylike child, the daughter of artists, who was first seen at the age of three, with a history typical of misdiagnosed infantile asthma. She had had what was called 'influenza at 11 months and became wheezy and from then on she had become subject to what was called 'colds'. These were of short duration accompanied by a high temperature. There was a history of eczema on both sides of the family and considered from the psychological angle, the atmosphere in the family was difficult, the child herself being of a passive listless type, and wholly unwrapped by the mother. This child was at once put on the form of diet worked out by the late Dr. Bircher Benner of Zurich and administered by a dietician personally trained by him. Improvement was immediate, the 'colds' ceased, and the child began to gain in weight. Some months later Jane developed a whooping cough and a small patch of broncho pneumonia developed in one lung but the wheezing on the lines to be described to cope with the listlessness and over attachment to her mother. Now 8 years later, she is a very lively vigorous little girl with steady good health.

Type 3

As an example of the continuation of asthma with catarrhal states and eczema I would like to instance a child Vincent Jones treated at Brambling House Children's Centre in Chesterfield under Rd. Bryan, by a therapist trained at the ICP, Miss P.M Triall.

Vincent was referred, amazingly for untruthfulness, but at the first interview it became clear that the more serious trouble was that he suffered from a chronic physical condition suggesting asthma. His mother described for example, that he would wake in the night with what she called 'squealing' and scratch himself for an hour waking the whole household. The curious fact, was that the next morning he remembered nothing about it. There was also a persistent skin affection problem at the ends of his fingers, and a dermatitis on the hands and in the flexures. Notes of the physical examination made later include the following Statements: 'inspiration harsh, a few coarse rales, left side of the nose blocked. There was a strong allergic history on the father's side, and of nervous breakdown on the mother's. Four other children were healthy. Vincent's I.Q. was 83, but his ability to carry out practical tasks became good. This was a long and obstinate case, in which the skin and chest conditions roughly alternated in severity. An illuminating incident in his

treatment occurred one day when Vincent arrived to the playroom with eczema and said he knew beforehand when his eczema was going to appear. During discussion or this feeling his breathing became asthmatic and remained so for part of the session, disappearing before the end. It is sessions like this, which give one the opportunity of watching the complex interaction of feelings, actions, realisation and sometimes disturbances in asthmatic children.

Vincent was a tough case and in his play showed all the phenomena I am about to describe. Eventually treatment succeeded. Vincent canalised his energies into such channels as becoming a drummer in the Boy's Brigade and marching in processions and the latest news of him 10 years after is that he had become a lorry-driver's mate handling hundredweights of potatoes in sacks and has remained in good health.

Type 5

To illustrate the type of case in which asthma arises spontaneously and without the accompaniment of eczema or catarrh, I would like to cite a little boy of 5, Ronald Prentice, who was brought to me during the war. The child illustrates both how such a type of asthma comes about and the difficulties, which attend its treatment. Ronald's story was as follows: While his father was away in the war and his mother and sister were evacuated to a farm in Herefordshire, he woke up three weeks after arrival there, in the middle of the night, crying and gasping for breath, and screaming violently. He began to wheeze, and said he had a 'pain in his tummy'. The mother did what she could to get a doctor, but they were far out in the country, and were unable to make contact with one till next morning. The child wheezed for five days. As soon as he had recovered, he was taken to a specialist in a nearby town and skin tests were done, and he was found to be strongly sensitive to horse, cow, dog, and feathers and mildly to dust and pollen.

From then on asthma occurred roughly once a month, lasting 5 days, when he would collapse into bed, and for three days refuse to eat. Between attacks there was some roughness of skin, but not enough to constitute an eczema. There was an elder sister healthy and boisterous. Ronald came for treatment on and off for about two years and his work showed the characteristics I propose to describe later. At the end of this period the asthma cleared.

To illustrate my class 4, in which asthma occurs in a child who suffers also, or has suffered, from a long series of other illnesses, I would like to take a little boy, still under treatment called John Bernstein. At 2 ½ years he had been investigated and treated at a London specialist asthma clinic, but after 18 months of injections the mother refused to cooperate further and further care of the child was undertaken by a General Practitioner. Subsequently, he was sent to the local Children's Hospital with a history of 'acute nephritis' and pulmonary tuberculosis, asthma, scarlet fever, measles, chickenpox, rubella, recurrent otitis media and bronchitis'. He showed

evidence of neurosis almost from birth. He was violently active from the time he could crawl, and so destructive as to be a menace to the family property.

There is a strong positive family history of asthma on both sides and the mother suffers from migraine under hospital care, almost everything listed in my introductory summary had been done for him - but the asthma persisted. Recently his younger sister had died of acute leukaemia.

Now, I do not want for a moment to suggest that all asthmatic children treated in the way I am about to describe get well and keep well, as with so complex a condition asthma, this would be an absurd claim to make. What I want to put forward is that in the success this approach has had with asthmatic children and in the material that is brought out during treatment, lies a hint of new facts concerning the nature of the condition itself.

Let us then pass to what we do for these children.

The basis of this approach is the analogy between an asthmatic attack and certain physiological states. Asthma is not a disease, as Diphtheria, for example, or Syphilis are diseases; that is, a fixed response of the tissues of the body to a single and identifiable agent, but is better described as a standardised reaction of a specific set of body tissues to a very wide variety of stimuli. The stimuli vary the localised reaction remains constant and this is what constitutes the problems.

We know a great deal about what actually happens within the body in an asthmatic attack, but we know it in the way a micro-photographer or a print analyst knows the structure of an oil painting by an old master. We do not know what was happening in the winter when he assembled this arrangement of lead and earths on stretched canvas or wood. We can see that is, the asthmatic attack and define and describe it, we do not know what is the experience of the child within the soma, producing the attack.

It is towards elucidation of this aspect of the problem that my work is directed. In my approach to the problem the child and his parents are seen simultaneously, but by different people. A careful history is taken from the parents with the bias towards the elicitation of data concerning the child as a person. The child, meanwhile, is presented with a series of opportunities to create for himself various productions with specified materials. Some of those, such as the Mosaic Test and World Technique, have been described and are fairly well known. Of some, like the Kaleidoblocs, Newspaper Game, and so on, no description has yet been published.

From this material, and what the child does with it, a picture is gradually built up of the child as a personality. In the meantime, the question of the way the child's day is spent, his diet, management of his leisure time, sleeping, play, etc. is gone into carefully, and an attempt made to gain an impression of family atmosphere and the relation between the child and his parents. An intelligence test is done and the school records inquired into. The child then goes to our specialist for physical activity. Here, Miss Margaret

Kirschner puts him in the position of making a free choice among a number of different physical activities in a room fitted with simple gymnastic equipment. All the child does is noted and recorded by a trained observer, and discussed and estimated at staff meetings; in the meantime, if this has not been fully carried out before the child comes to us and a report sent, a detailed physical examination is made by the Paediatrician, and the results recorded.

Lack of beds is a very serious handicap and only in exceptional instances is it possible to see a child in an attack, so reliance has to be placed upon accounts given by the parents.

The procedures undertaken with and by the patient in his first one or two visits, give the physicians and therapists working with him a general idea of the type of child we are dealing with, and the stage of development he has reached. From then on, however, he finds himself with a wide range of possibilities, either of imaginative play or physical activity, since provision is made for free use of water and mouldable substances, paint, paper and constructive and dramatic play. On our part, attention is focussed upon gaining an understanding as to what his asthma means to the child, and what are the circumstances in which it appears.

Now just as there is general agreement about the phenom and the stimuli in asthma, so there is a consensus of opinion that under psychological treatment of my kind, asthmatics reveal themselves as aggressive, and they may have a smothering relationship with their mothers.

As I have said, although there is a surprising variety among the personalities - and circumstances of our asthmatic children, yet there is a definite similarity in the work they produce. The first quality about it, which strikes the physician, is the constant appearance of violence.

This violence in certain cases is certainly aggressive, and equally definitely has, in some, a. relation to the child's affects concerning his family. On closer study, however, there is something odd about this violence and it is this that I want to try and convey to you.

If you have not seen our department you must imagine a. series of rooms, two opening out of each other and the others off a corridor and fitted up in different ways. In one the walls are tiled and poster paint provided, which is a good medium for painting or splashing upon them, another is furnished with sinks, tubes, and covered lights for water play and the exercise room has wall bars, slide and poles and the others a solid walled corner, a house, a shop, dolls house etc. Several children are under treatment at the same time, of varying ages and for different complaints. The floor is shut off from the other floors, no adult is allowed in and the children are free to do what they will. Considerable emphasis is laid, with each child, upon the explanation that this is a. special place where special things happen and not at all like home and school. It is also explained to the children that what they do or say is private between them and their worker, and will not be reported at home.

In the middle of the main room are sandtrays and world cabinets and it is from their use of these that our most fruitful understanding has been gained of the processes that go on in an asthmatic child's mind.

Now although the use made of these tools by each individual child varies, there are certain common characteristics, which appear in all. In the play of those children many types of violent happenings are depicted simultaneously and incongruously but there is, however, no sense about the pictures. Violent events, or noise, or bizarre happenings all occur at once. To the child, they appear connected but the connections are not apparent to the observer. Violence mostly takes place in several directions, simultaneously up/down - in/out - along/ and back and without organisation. It is as if the child wishes to unload into visible form a three dimensional block of disturbing sensations. If the psycho analytic view be taken as to the existence of basic drives of aggression and sex, then this is all straight going and interpretation along these lines will be so near to what I believe to be the real meaning of this violence as to bring relief.

If, however, interpretation along psychoanalytic lines is not given and the work done by the child is closely watched, carried out with him and sympathetically listened to, a curious impersonality appears in the material. The child is violent but the violence does not fit exactly within the term 'aggressive'.

Ronald Prentice, for example. Spent a great deal of his time experimenting with the forcible use of water, not directed at anything, but in relation to its power of carrying, making arcs, fountains. etc. His 'Worlds' were filled with symbols of movement such as trains, fire engines, vans, cars, river boats etc. Fights, where they did occur, were again vague and amorphous.

Jane Eikins after playing out a great deal concerned with food, which referred back to her change of diet, is noted as having great pleasure from physical release in the exercise room and fearless balancing and sliding, making louder and freer noise, acting as naughty and nice lion, spider chasing people etc.

Alice Heath was a coarse child and excessively inhibited to begin with, but even then her first 'world' was an arch with a fire-engine and a police-car, implying, though not stating violence. Later on, her time was largely spent in violent physical activity.

Vincent Jones was active from the beginning. His family complained that he threw the furniture about at home and in the play room he used the usual power symbols, fire engines, cars and so on but also spent much of his time in violent sawing piling up the furniture, and throwing himself into violent physical activity.

This violence is therefore generally expressed by the children in symbols of power, such as trains, galloping horses, ships, aeroplanes, buses,

traffic, lions, volcanoes, and so on, and very much in the violent use of water - but this is a generalised impersonal sort of violence that 'just happens' but does not happen against another thing or person.

In Miss Kirschner's department also, the same development takes place: starting with the wheezy respiration and the cramped inhibited movements of the typical asthmatic, the movements gradually loosen up and increase in force and swing, and in the satisfaction they give to the child. The child's whole aspect begins to change, the wheezing diminishes and finally disappears, the skin colour improves, the expression of the child changes and gradually a phase appears in which the child initiates and responds to violent and prolonged movement.

A very striking aspect of this period is the type of incident in which the child arrives in the activity room with embarrassed breathing and after a pillow fight with very dusty cushions the wheezing clears and breathing becomes normal. I have known this to take place even in children reported as showing strong positive reactions to dust.

It may be felt that this is in direct contrast with the accepted views as to the need for teaching relaxation in the handling of the respiratory sides of asthma, but the contradiction is only apparent. The type of work undertaken by the child in the activity room issues from the child's desires and interests, and is led out and encouraged by Miss Kirschner. Violent movement demands good respiration, and expiration comes about naturally through the demands of the body and the automatic response of the child's when his attention is concentrated on an exciting physical goal. Later, when this stage has been reached and passed, definite work is initiated by Miss Kirschner on the control of breathing and the achievement of relaxation; but by this time, the child's interest is fully won, and so this can be done with his full cooperation.

The fascinating fact, which has emerged from much study in this way, of asthmatic children, is the profound dissociation, which in many asthmatic children exists between their bodies and themselves. One boy, for example, seen at the age of 7 for very severe asthma (and now doing well in forestry) had no idea at all, when his eyes were shut, where the outlying parts of his anatomy were, or what they were doing; and when, after a friendly contact with him had been gained, he was told for example, to bend forwards, he would as likely as not bend back. This dissociation between the directing 'self' and the behaviour of the body is, I believe, an essential characteristic of the asthmatic child, and of the condition itself.

If one pauses for a moment to picture what I have been describing, an essential contrast presents itself at once between the type of scene and the child as we know him in an attack of asthma. There is hardly anything that tears at the heart more agonisingly than the spectacle presented by a small child in the grip of a bad attack of asthma. Here a sentence in Dr. Fisher's paper epitomises the crux of the problem. After describing most wisely what the general handling of the asthmatic child should be, Dr. Fisher advises "a

regular daily routine of life free from over-exciting and physically exhausting experiences".

To make intelligible my criticisms of the conceptions lying behind this advice, I would like to describe a scene in the treatment at the Institute of Child Psychology of the boy of 7 whom I cited earlier as representative of Class 4 of children; those in whom asthma appears in association with a long series of other illnesses. His parents one day telephoned at his treatment hour that he was in the middle of an acute attack and could not come. Nevertheless, I was able to persuade them to bring him in a taxi and the child arrived, presenting that heartbreaking spectacle, which is a child in the middle of a severe asthmatic attack. I propped him up with cushions on my sofa and stood a wooden mosaic tray up on edge on his chest, offering him one or two chestnuts (conkers) with a suggestion that he should try to throw these at the tray and see what sort of sound they made. Being a responsive, friendly child, he tried, and feebly flicked one or two at the board. Now conkers make a satisfying noise when striking at a thin but rigid board, and he became mildly interested in this sound. As his interest grew, so the movements of his right arm grew stronger and, I, by imperceptible degrees, moved the board further away from his face along his chest.

At the end of about 10 minutes he was sitting bolt upright slightly away from the cushions and throwing with some definite vigour, the acuteness of the attack was passing, breathing was easier, and the acute anxiety on his expression diminishing. All this time I was making encouraging noises.

After a while, he found the sitting position on the couch with legs extended, cramping to the arm and slid off the couch to throw better. (we have always ready an inexhaustible supply of useful conkers) and the 'board was exchanged for a thin partition which forms one wall of the room and gives back a satisfying sound. The violence of his movement, the noise he was making rose in a steady crescendo, till, at the end of roughly twenty minutes, John was leaping about the room throwing with tremendous vigour at walls and doors, and obviously enjoying enormously the sounds of the crashing conkers - the asthma attack had disappeared.

This surprised him so much that on moving across the hall to rejoin his mother in the waiting room, his body attempted to fall back into the position it had held on arrival and to recreate the asthma. In this it was partially successful. But an experience of this kind is a landmark for the child — he has known and felt in his own person, that the torment of an asthmatic attack can pass into, or be relieved by, violent undirected movement. From this point the child's attention can be drawn to this phenomenon and experimentation be encouraged.

Now here We may seem to be stating a paradox — since Dr Fisher puts it "It is a matter of clinical observation, that, in the early years of life, emotional excitement, especially if accompanied by some degree of physical exhaustion, is one of the main exciting causes of the asthmatic attack". How are these two statements, his and mine, to be reconciled? Here we come to

the heart of the problem. What troubles the asthmatic child, in our experience, is not the factor of excitement in itself, but that of the possibilities that are open to him for the expression of excitement. What terrifies a child, we find, and gives rise to the asthmatic attack, is not the excitement but the power of being excited that the child feels rising within him and the absolute lack of ability to canalise it into expression. This is at any age and in any personality capable of feeling it, a terrifying experience, so terrifying that it breaks the bounds, as it were, of the power of conscious realisation and bursts into somatic expression as an asthmatic attack.

As to the factor of physical exhaustion, when Alice Heath mounted the stairs from the playroom to the waiting room on her first visit and met the physician who had conducted her physical examination on the stairs, she sank down in an asthmatic attack, as a small sympathy evoking heap. Later in the treatment when I fetched the same physician downstairs to look at her, she had already worn out two members of staff with violent physical activity. If this strange force of interior, apparently indifferenced energy, which I suggest that we must designate by the capital letter 'E' is flowing freely: it is in my experience practically impossible to tire out an 'asthmatic' child. As to what happens when the opposite line is taken, I may perhaps illustrate from the case of a child whose drawing I have passed round. This boy was referred to us during the war, at the age of 3, for convulsions and spent a year in our hostel. The convulsions ceased and a sturdy energetic normal child emerged. He returned home and began to have recurrent bouts of what his most competent doctor felt must be influenza as he would go white in the face and be overcome with acute lassitude. When put to bed his temperature would rise and a state simulating influenza develop. After a while, at her wits end, his mother consulted me. As she was of unusually cooperative temperament, I suggested to her that she try the opposite line and that next time this happened, she should invent a game that would immediately bring him into violent movement. She did this, and reported to me that the colour came back to his face, the lassitude disappeared and by the evening he was normal. As he grew older this boy went to a day school some distance away and I urged the importance of rough games and football. His excellent doctor, however, still impressed with the accepted 'delicacy' advised the opposite and that two days in the week he should come home and rest. Now his mother writes to me that asthmatic attacks are developing.

This boy's brother was one of my earliest asthmatic cases — his history was like any of these I have given above, with a devoted mother desperately moving from place to place to find a neighbourhood where delicate eczematous bronchitis little boy could find ease. This boy now 17, has this year left school to go into his father's office after having spent a good part of his last years at school as a prominent footballer. For the whole of his school career, there had been no asthma and none has appeared since leaving - yet so difficult is this concept for parents to grasp that with her second boy both mother and physicians are caught in the same trap.

What is, therefore, happening in those children and in our handling of them?

It seems to me from the evidence at hand that three things are happening all at once:-

The first and phenomenon is an experience by the central self of the child of an up rush or charge within his inner citadel which we can only liken to those of electricity in a cell undercharge this "feeling" or "sensation" (there is at present no word which accurately resembles it) is diffuse and as it were, all over at once.

Its diffuseness brings into being the second element in the situation, an absence of focus. The asthmatic child cannot get a balance between his central self, the self that wills and directs and this force arising within him. He, his inside self, and it, have no proper relation to one another. First one is on top then the other and the child moves in a kind of fog of 'feeling'.- This experience is terrifying, it produces a sense of isolation and of despair, the child is 'lost'. Unaided he cannot cope with the force in which he is immersed and there comes to his relief the physiological phenomena of fear. Breathing becomes tense, the bronchioles begin to exude and contract and a familiar situation appears. The parents and the doctors begin to recognise what is happening and give it a name terror of the unknown is past, land is sighted and all is familiar once more, 'I have asthma' the child says to himself and the adults to each other.

From my own childish experience and from many children, I have learned the great comfort of having a name given to one's complaints with the shelter of a name, something that everyone has heard of, that is familiar and can be discussed, any suffering is bearable. The child with its terrifying experience once named is back in the community once more.

But the experience has marked him the failure to understand and to focus what is happening inside him is altogether terrifying and must not be allowed to happen again. Anything is preferable to this and so the third element comes into operation: the asthmatic child shuns occasions of possible failure. "Who knows" " he seems to say, "what sort of a failure this might be – you say it is only a party or an arithmetic exam or a race, but how do I know you know, it might very well be one of these that turns into the awfulness". To illustrate the awfulness of this, one boy, the one who bent back instead of forward, made a son the ground, were set upon by a WORLD in which human beings lying on their back ring of powerful zoo animals, with the keepers fleeing in the corners from the attacks of other animals.

We are brought back, therefore, to the question of this force the children and the query as to what it can be.

Sick children are dependant for their assistance on the medical professions, on the attitudes and decisions of the physicians and nurses whom their distress calls to their aid. But in modern life, and in the attitudes we adopt to the potentialities or the world in which we live, a curious dichotomy has developed, which is reflected in the organisation of and the attitudes within the medical profession.

As a community we have during the past 57 years, passed through two world wars in the course of which everyone of us must have had personal experience of extremities of violence and of the destruction and horrors caused by it. As have all of us, as individuals, and as part of the community to make our own adjustment, both to these facts as external to ourselves and to our own interior shock and suffering in relation to them.

In times past gala executions, public flogging, bear-baiting, cock-fighting, judicial tortures, and the rest created an external community experience into the pattern of which experiences of the sort we have been considering could comfortably fit. Today, on the other hand, particularly in medicine, dichotomy has developed. When the violence happens to and about, or is demanded of us, us, we must meet it adequately and respond correctly. The moment external appearance changes the atmosphere we offer to the child in the range of medicine is one of the strict impersonality, quiet voices, quiet words, doses of medicine and injections, movement about vast hospital corridors, ordered out patient clinics and a kind but firm nursing staff.

In other branches of medicine, should psychological treatment be prescribed conditions are exactly reversed. Here contact is with one physician or therapist, in the strictest seclusion and subjectivity, what happens within this privacy remaining the property of only those two who take part in it. Changing from this room, the child is once more in the world which excludes from its consciousness knowledge of the violence it fears and has experienced. The child finds himself there alone with his problem and the physiological groundwork of the somatic response to fear offers him a ground work for the pattern of his asthma. From the subjective side therefore, until he is made comfortable in recognition of the reality of his inner experience and the ability of his surrounding adults to understand and control it, his asthma will remain.

Whether this violence which we encounter in the asthmatic child is stronger in them than in other children, we have no means of estimating. From the experience of those of us who have been using this approach, it seems that there is an essential flow somewhere in the asthmatic child's make-up and asthmatic diathesis, which expresses itself in a difficulty in coping with forces that arise within him whether these are entirely endogenous or entirely respondent to stimuli from outside or what is more probable, a mixture of both, there is no evidence to say. But there is a further element in the asthmatic personality, which complicates the issue.

This is an extraordinary fear of failure, which causes asthmatic children to retreat into the misery of an asthmatic attack rather than to risk the experience of defeat. Putting these two characteristics together you have a temperament with inherent difficulties to overcome of no mean order. Put this personality within a body whose tissues have inherited a tendency to vasomotor instability and thermolability and you have a child who is almost certain to react to the unavoidable rubs and insufficiencies of life with morbid somatic phenomena. What is happening in this situation is not an illness, as,

for example, whooping cough or pneumonia is an illness, but an evidence that the difficulties of management of his interior stresses have temporarily overwhelmed the child and that this despair and retreat is finding for itself dramatic expression. The asthma is not a disease in itself but a sign that an interior breakdown of adaptability has occurred.

This breakdown is, I believe, the central factor in all cases of asthma in childhood. I am not competent to say whether the same is true of asthma in adults, though the few cases I have had the opportunity of studying by the same methods give me a very strong suspicion that something of the same may be true here also. But as with all questions of failure under strain, in the asthmatic attack itself the question of threshold is all important.

This is where, I believe, that my views and the experience of other workers particularly those whose approach to the problem is wholly through physical means, meet and compliment each other. An asthmatic child can often a particular type of strain and carry on without marked distress, or with only a slight increase in wheeziness so long as this remains the only cause of tension. But if a heavy cold with the acute night discomfort of the blocked nose, some occult sepsis, enlarged tonsils or any one of the stimuli already described are ADDED to the burden of coping with this primitive violence within him then the struggle becomes too difficult and the child breaks down into a somatic expression of his distress.

It is this interaction or underlying state and precipitating cause, which, it seems to me, it is important for general practitioners, school and family to understand. Many things can be done and in many ways to learn the tension between the child and himself - to make the soma function more smoothly, to make the physiological phenomena of fear harder to evoke. All these tend to help, the child, if they do not him that he is 'asthmatic' but they do not touch the core of the problem.

To be successful, the family must be brought to understand that the asthma is a thermometer of interior adjustment and therefore the disappearance of the attacks means success in total personality adjustment to life. They need to be won to patience with the child in his struggles and to acceptance of the point of view that growing up is a lengthy matter and satisfactory development is not to be achieved overnight.

The case of Ronald Prentice illustrates well the kind of difficulties, which will be met with. At the end of the war I moved back to London and ceased to be immediately available to help Ronald. I lost sight of him for some seven years. At the end of that time I found that Ronald had kept well so long as the outlets for energy, which we had arranged remained available for him and the background stable. When however a breakup of his parents' marriage and his mother's remarriage became combined with the move away to a rather conventional type of boarding school was chosen, the difficulty reasserted itself and the asthma reappeared. The mother maintained however that the quality and character of the attacks were different and that the general improvement of personality remained. All the same the decision taken

was that this form of treatment had been given a fair trial and that now something practical must be resorted to.

Although I did not see Ronald I heard enough of him from another of the boys in the same school to understand that at this stage in his development, adjustment to that type of school would be really difficult. Once again asthma with its 'respectability', was the natural way out for him. His attacks occurred at school not at home.

What is therefore needed in the treatment of asthma in children is a reduction of the threat to interior stability in any way that can be brought about without 'fixing' the idea of being ill. As one of our little girls said to us when first introduced to the exercise room "Oh I can't do that, I have asthma". This reduction is in our approach affected by the use of dietetic measures, by ordinary physical therapy, by regulation of regime, etc. All these will be effective at certain times and with certain children but the central problem remains. This is the education of the asthmatic subject to understand his problems as through the patient cooperation of those who work with him to find a way to face and to use this primitive within him, so that instead of escaping from it into somatic byways he works out ways in which this driving force within him can be put to the service of his own development and that of the community.